

**Beneski Chiropractic & Wellness Center**  
**New Patient Registration Form**

**Patient Information:**

Date \_\_\_\_\_ SS# \_\_\_\_\_  
Patient Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Email \_\_\_\_\_  
Sex  Male  Female Age \_\_\_\_\_ Birthdate \_\_\_\_\_  
 Married  Widowed  Single  Separated  Divorced  Minor  
Occupation \_\_\_\_\_  
Patient Employer/School \_\_\_\_\_  
Employer/School Address \_\_\_\_\_  
Employer/School Phone \_\_\_\_\_  
Spouse's Name \_\_\_\_\_  
Spouse's Birthdate \_\_\_\_\_ SS# \_\_\_\_\_  
Spouse's Employer \_\_\_\_\_  
Whom may we thank for referring you? \_\_\_\_\_

**Phone Numbers:**

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Best time and place to reach you \_\_\_\_\_  
**IN CASE OF AN EMERGENCY, CONTACT**  
Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

**Assignment and Release:**

I, certify that I, and/or my dependant(s), have insurance coverage with \_\_\_\_\_ and assign directly to Dr. \_\_\_\_\_ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

\_\_\_\_\_  
Signature of Patient, Parent, Guardian, or Personal Representative  
\_\_\_\_\_  
Please print name of Patient, Parent, Guardian, or Personal Representative  
Date \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

**Insurance Information:**

Subscriber's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Relationship to patient \_\_\_\_\_  
Insurance company \_\_\_\_\_ Group # \_\_\_\_\_

**Past Medical History:**

Primary Care Physician \_\_\_\_\_  
Address \_\_\_\_\_  
Phone \_\_\_\_\_  Please do not contact my primary care physician  
Date of Last: Physical Exam \_\_\_\_\_ Spinal X-Ray \_\_\_\_\_ Blood Test \_\_\_\_\_  
Spinal Exam \_\_\_\_\_ Chest X-Ray \_\_\_\_\_ Urine Test \_\_\_\_\_  
Dental Exam \_\_\_\_\_ MRI, CT-Scan, Bone Scan \_\_\_\_\_

**Past Medical History-Continued**

Place a mark on "yes" or "no" to indicate if you have had any of the following:

- |                     |  |                    |  |                    |  |
|---------------------|--|--------------------|--|--------------------|--|
| AIDS/HIV            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Alcoholism         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Allergy Shots      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Eating disorder    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Appendicitis       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Chem. Dependency   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Bleeding Disorders | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Breast Lump         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Asthma             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Emphysema          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Cataracts          | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Cholesterol   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chicken Pox         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hypertension       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Epilepsy            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mononucleosis      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Goiter              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Gout               | <input type="checkbox"/> Yes <input type="checkbox"/> No | Osteoporosis       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart Disease       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hernia             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Polio              | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Prostate Problem    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Problems   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Herniated Disk      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Multiple Sclerosis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcers             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Kidney Disease      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Migraines           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Miscarriage        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pacemaker          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Parkinson's Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |                    |  |                    |  |
| Other               | _____  |                    |  |                    |  |

Are you pregnant? Yes No Due Date \_\_\_\_\_

**Health History:**

**Habits:**

- Smoking Packs/Day \_\_\_\_\_
- Alcohol Drinks/Week \_\_\_\_\_
- Coffee/Caffeine Cups/Day \_\_\_\_\_
- Diet \_\_\_\_\_
- Recent weight loss effort \_\_\_\_\_

**Medications:** None   
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Allergies:** None   
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Vitamins/Herbs/Minerals:** None   
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Family History:**

Please list any family members that have past or present health conditions. (Heart disease, cancer, diabetes, stroke, arthritis etc.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Website Access Registration:**

Please sign below to receive access to our website for Patient Only Information and to provide permission to keep you up to date on office events, health information, and specials. You will also receive a free subscription to the Healthy Living Newsletter.

Signature: \_\_\_\_\_